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Electronic Newsletter

Perinatal network

Maryland Department of Health and Mental Hygiene

The Perinatal Network News is a publication of the Department of Health and Mental Hygiene's (DHMH) Center for Maternal and Child Health (CMCH). It is funded through a Crenshaw Perinatal Health Initiative grant provided to the Montgomery County Health Department.

The publication is intended as a communication tool for sharing perinatal information for a statewide audience, with information and resources that address statewide issues. It is designed as a vehicle to encourage collaboration and networking throughout the state. The newsletter provides an opportunity to share information on preconception and perinatal health issues and priorities, infant morbidity and mortality, county statistical trends and perinatal and child health indicators. It is an opportunity for local programs to share their strengths and insights as well as opportunities to ask for feedback and assistance in solving a local problem.

To ensure that this newsletter is a success, we need and encourage your participation. Please let us know of any items you would like to contribute, or if you have suggestions for topics or areas you would like to see covered.

Contact Andy Hannon at 410-767-6716 or e-mail at hannona@dhmh.state.md.us

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The Maryland PRAMS (Pregnancy Risk Assessment Monitoring System) Project

Diana Cheng, Medical Director, Women's Health, Center for Maternal and Child Health, Maryland DHMH

PRAMS is a surveillance system established by the Centers for Disease Control (CDC) in 1987, to obtain information about maternal behaviors and experiences that may be associated with adverse pregnancy outcomes. PRAMS projects are currently underway in 29 states and New York City. All surveys include a core set of standardized questions, which allows for multi-state analyses. In addition, each state can add questions tailored to meet its needs. For the 2001-2003 survey time period, the core section of the survey included questions relating to prenatal care, obstetric history, smoking, alcohol use, physical abuse, contraception, economic status, maternal stress, and infant health. The Maryland-specific section of the survey included questions on assisted reproduction, contraceptive use, depression, oral health, bedrest during pregnancy, social services, and seatbelt use.

In Maryland, mothers who have recently delivered are randomly selected to complete an 86-question survey about their health, behaviors, quality of care, and experiences in the time before, during and shortly after their pregnancies. Each month, a stratified random sample of approximately 200 live births is selected. The 2003 sample is stratified by maternal age (<35 years, > 35 years) and infant birth weight (<2500 grams, and >2500 grams). This sampling frame over-samples mothers who have delivered a low birth weight infant (<2500 grams) as well as mothers who are 35 years of age or older. The responses are confidential and are completed by either mail or phone.

The recently released May 2005 publication, "Maryland PRAMS Report, 2003 Births" is the third report of Maryland PRAMS survey results. The report covers the responses of mothers who delivered between January 1 and December 31 2003 and represents a 73 percent response rate for that time period. The first two reports covered responses from mothers of 2001 births and 2002 births. A response rate of at least 70 percent is recommended by the CDC for data analysis. Table 1 summarized some findings for 2001, 2002 and 2003 births and compares them to Healthy People 2010 objectives.

Key findings from 2003 Maryland mothers include:

- * Forty-one percent of all pregnancies were unintended.
- * Seventy-eight percent of mothers began prenatal care during the first trimester (<13 weeks) of pregnancy and less than one percent received no care. The primary reasons given for not receiving early prenatal care were lack of awareness of the pregnancy and difficulty in obtaining an appointment.
- * Sixty-five percent of mothers reported one or more medical complications during pregnancy and 21 percent of these women were hospitalized for one or more days. The most common medical

complications reported were preterm labor, severe nausea or vomiting, vaginal bleeding, high blood pressure or edema, kidney or bladder infection, premature rupture of the membranes, and diabetes.

- * Eleven percent of women smoked during pregnancy and 10 percent reported using alcohol.
- * Four percent of mothers reported being physically abused by a husband or partner during pregnancy.
- * Forty-eight percent of mothers had a routine dental visit during pregnancy, and 26 percent needed to be seen for a dental problem.
- * Thirty-five percent of mothers participated in the WIC program during pregnancy.
- * Twenty-nine percent of mothers stated that their deliveries were paid for by Medicaid/HealthChoice and 68 percent cited private health insurance/HMO as their source of payment.
- * Fifteen percent of newborns were admitted to a neonatal intensive care unit.
- * Seventy-eight percent of infants were breastfed after delivery, and 65 percent were breastfed four weeks or longer.
- * In terms of sleeping position, 64 percent of infants were usually placed to sleep on their backs.
- * Twenty-one percent of mothers reported they were not using postpartum contraception. The most frequently cited reason for not using contraception was that they were not having sex.
- * Twenty-two percent of women reported being at least moderately depressed during the postpartum period.

The entire Maryland PRAMS Report, which includes a copy of the survey, can be viewed online at www.fha.state.md.us/mch/html/prams_fs.html. The PRAMS project in Maryland is a collaborative effort of the Center for Maternal and Child Health (CMCH), the Vital Statistics Administration (VSA) of the Maryland Department of Health and Mental Hygiene, and the CDC. For further information, contact Diana Cheng, M.D. at 410-767-6713, Principal Investigator of Maryland PRAMS.



FIMR/Mortality Reviews as Tools for Assessing MCH Systems

Since the launch of the Fetal and Infant Mortality Review (FIMR) in the 1980s, other types of mortality reviews have been adopted. This article examines FIMR in relation to two other mortality reviews, Child Fatality Review (CFR) and Maternal Mortality Review (MMR), and explores how their approaches to reviewing the events of infant/fetal, child, or maternal death can complement one another.

The three mortality reviews are compared according to their scope, structural and organizational characteristics, and review process features. Information on improving coordination—including the conclusions of representatives from FIMR, CFR, and sudden infant death syndrome programs who met in December 1997 and examples of existing coordination among the reviews—are presented.

Recommendations for sharing best practices among the reviews are also provided and include the constellation of participants in the review process, strategies relating to implementing the process itself, and the use of findings generated by the review.

The role of the State Title V program in the coordination of the review of the processes and in the sharing of best practices is discussed, as well.

The authors conclude that “the likelihood of real change and improvement in services and policies will be facilitated if findings are disseminated widely at both the local and state levels to consumers, professionals, and key policymakers. To this end, a strong partnership between local health departments, social service agencies, MCH consumer advocacy groups, and state maternal and child health consumer programs in the conduct of mortality reviews is essential.”

Hutchins E, Grason H, Handler A. 2004. FIMR and other mortality reviews as public health tools for strengthening maternal and child health systems in communities: Where do we need to go next? *Maternal and Child Health Journal* 8(4):259-268.

Maternal and Child Health Journal, Fetal and Infant Mortality Review: Historical Foundations, Evaluation Findings, and Future Directions. Available to the journal's subscribers at www.kluweronline.com/issn/1092-7875/current.

For information on FIMR programs in Maryland, contact Joan Patterson at 410-767-6727 or jpatterson@dmmh.state.md.us.

Healthy People 2010 Objective	Healthy People 2010 Target	Maryland PRAMS 2001 Births	Maryland PRAMS 2002 Births	Maryland PRAMS 2003 Births
Preconception Factors				
Increase the proportion of pregnancies that are intended.	70%	57.9%*	56.1%*	58.8%*
Increase the proportion of pregnancies begun with the consumption of at least 400 ug of folic acid each day from fortified foods or dietary supplements by nonpregnant women aged 15-44 years.	80%	31.2%	28.4%	31.0%
Prenatal Health				
Increase the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy.	90%	78.1%**	75.8%**	78.2%**
Reduce cigarette smoking among pregnant women.	2%	9.4%	8.3%	11.1%
Increase abstinence from alcohol by pregnant women.	94%	91.9%	93.4%	90.1%
Increase abstinence from binge drinking by pregnant women.	100%	99.1%	99.4%	99.5%
Postpartum Maternal and Infant Health				
Increase the percentage of healthy full-term infants who are put down to sleep on their backs.	70%	61%	63.2%	64.0%
Increase the proportion of mothers who breastfeed their babies in the early postpartum period.	75%	76.5%	72.4%	77.5%

*PRAMS data includes only information on pregnancies that end in live birth

**First trimester defined by PRAMS as <13weeks

Sharing Strategic Experiences: Spotlight on Montgomery County's Collaboration Council on Children, Youth and Families

Jody Joy, Editor, Perinatal Network

In an effort to strengthen and deepen the networking aspect of the Perinatal Network in Maryland in which counties across the state might learn and benefit from the experiences of others, this spotlight on Montgomery County's Collaborative Council is presented.

As one of Maryland's more densely-populated counties, Montgomery has had to respond to the challenges of rapid urban/suburban growth, a dramatic increase in immigrant populations and the resultant impact on agencies and organizations responsible for public care. In particular the Collaboration Council, "...oversees collaborative efforts among different agencies who share a common goal to improve the well-being of children, youth and families in Montgomery County."

The Council's goals as stated in their mission are: "When the programs or intents of two or more agencies serve the same vision set forth by the community in Council initiatives, we step in to form partnerships among them so that efforts are not duplicated. To that end, our goals are to:

- ◆ Develop, promote and implement a comprehensive "agenda" for Montgomery County's children and families. We call this agenda The Children's Agenda, and it is made up of seven desired outcomes or goals that reflect the community's vision of life for children and families in Montgomery County.
- ◆ Promote collaborative partnerships among public and private service providers in order to efficiently meet the vision outlined in The Children's Agenda. Recommend to the County Executive, County Council and Board of Education the priorities and strategies that best promote community participation in achieving the vision.
- ◆ Partner with state and local government to improve the delivery and financing of the human service system.
- ◆ Evaluate the effectiveness of strategies created to improve the well being of children and families, facilitate the cross-agency community's efforts to improve systems and enhance the Council's progress.
- ◆ Increase readiness and ability to implement the community agenda."

The Collaboration Council's Web site is a wealth of information that details how as a Local Management Board (one of Maryland's 24 LMBs) created by the state for multi-agency coordination purposes, the Council is active in the areas of planning and coordination, administration and oversight, fiscal management, public awareness and accountability.

How the Council is organized to accomplish its task and to make sure the voices of all stakeholders are heard, key initiatives and programs as well as publications that outline projects and activities are all available on their Web site, which you can access by clicking on the logo below, or going to www.collaborationcouncil.org.

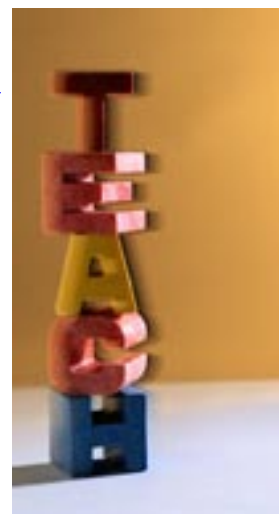
In the current era of budget constraints paired with increasing public need for mother-child services, strategies that emphasize collaboration, elimination of duplication of effort and best practices are strategies that produce effective results.

Providing Language Services in Small Health Care Provider Settings: Examples from the Field

The report describes a variety of ongoing activities designed to improve language services in small health care settings. The National Health Law Program, with support from the Commonwealth Fund, conducted site visits and phone interviews at small health care settings (defined as those with 10 or fewer clinicians). Changing demographics, along with heightened federal and state policies, have increased the need for effective models of providing services to individuals who are limited English proficient (LEP). Unfortunately, many providers are challenged by a shortage of knowledge and resources, which can create barriers to care. To assess current innovations, the National Health Law Program conducted site visits and phone interviews at small health care provider settings. Certain services emerged as "promising practices"—creative, effective methods that are replicable by other small providers. These practices include recruiting bilingual staff for dual roles (e.g., front desk and interpreter positions); ongoing cultural and language competency training for interpreter staff; using community resources like hospitals, managed care organizations, students, and volunteers; and capitalizing on underutilized funding sources. The authors include an eight-step plan to help providers develop a strategy to meet the needs of their LEP patients and the community.

To view the report:

www.cmfw.org/publications/publications_show.htm?doc_id=270667



Improving Communications: Howard County Health Department Perinatal Case Management

Lisette K. Osborne, RN, MSN, CRNP, Director, Bureau of Community and Family Health, Howard County Health Department

Mis—or missed communication can be a source of frustration for any program. Attempting to keep staff informed between programs and across bureau lines can be a daunting task, but is critically important particularly when clients access services from multiple programs. The Howard County Health Department recently met these communication challenges head on, implemented organizational changes, and created a forum to open dialog between programs with tangible results.

In order to increase internal communications, the first change was organizational. Several outreach programs, including Women, Infants and Children (WIC), Maryland Children's Health Program (MCHP), and Administrative Coordinator Care Unit (ACCU) were moved into the Bureau of Community and Family Health (CFH). Already residing in CFH were clinical and home visiting programs, including prenatal clinic services and perinatal home visiting services, which includes three Healthy Start based programs and post partum home visiting.

The second communication improvement came through the creation of a monthly perinatal case management meeting. The meeting is chaired by the Bureau Director and includes program directors and staff from the prenatal clinic, MCHP, ACCU, WIC, the FIMR Coordinator, and the three Healthy Start based home visiting programs. As staff includes a mix of nurses and social workers, the meeting provides a multidisciplinary outlook on numerous issues. Monthly agenda items are provided by the staff and have addressed such issues as standardization of documentation, MCHP coverage and emergency Medical Assistance, service gaps, and substance abuse treatment availability. In addition to specific agenda items, each meeting has a time for case management allowing staff to present difficult or complex cases for input from the multidisciplinary team members.

This is a highly productive group of individuals. Within the few months that the group has been meeting, outcomes include:

- ▲ Creation and implementation of a new standardized chart for all home visiting programs (Healthy Start, Family Options, and African-American Outreach.)
- ▲ Creation of a laminated provider fact sheet listing all available Health Department perinatal programs, including program descriptions and contact information, to be distributed to local OB providers.
- ▲ Creation of an internal communication procedure and format.
- ▲ Improved client links between programs.
- ▲ Expedited WIC nutritional screening and decreased wait time for initial appointment.
- ▲ Identified service gap for substance abuse treatment for prenatal clients and initiated conversation with treatment provider.
- ▲ Identified service gap for DSS clients and initiated conversation with DSS administration.
- ▲ Standardized case management procedures.

Through open dialog in a forum encouraging discussion and creativity, service gaps are being identified and efforts are being generated to improve available services. Clients that cross program borders now have program communications crossing borders resulting in improved service to Health Department clients.



Reducing the Risk of SIDS

The American Academy of Pediatrics' Healthy Child Care America Back to Sleep Campaign has published three brochures about reducing the risk of sudden infant death syndrome (SIDS). A Child Care Provider's Guide to Safe Sleep presents data and information about SIDS and safe sleep practices and is available at: www.healthychildcare.org/pdf/SIDSchildcaresafesleep.pdf

A Parent's Guide to Safe Sleep includes information about working with child care providers to ensure that safe sleep practices are used both at home and in child care settings. It is available at www.healthychildcare.org/pdf/SIDSparentsafesleep.pdf

Tummy Time contains information about the importance of allowing infants to spend supervised time lying or playing on their stomachs and is available at www.healthychildcare.org/pdf/SIDStummytime.pdf

For information about SIDS in Maryland, contact Jean Edwards, Center for Infant and Child Loss, 410-706-0200.

Health on the World Wide Web

Lynn Matava, Coordinator Special Programs, Health Services, Wicomico County Health Department

Seemingly everybody is “online.” By 2001, 57.9 percent of Marylanders reported having internet access in their homes (U.S. Census Bureau, 2001). With endless amounts of information available in mere moments, it can be difficult to distinguish between the good, the bad and the ugly!

There are over 100,000 health-related Web sites out there. What’s more, anyone can and may post a Web site. The internet may very well be the last place—in this world—that is not governed by any one entity. What this means for information-seekers is that we need to be wary of quality, accuracy and credibility.

The National Library of Medicine has developed a comprehensive system of online databases to assist both consumers and providers in quickly accessing valuable, accurate health information. A visit to www.medlineplus.gov can guide individuals to easy-to-digest information on over 700 diseases and conditions. Additional features include a medical encyclopedia and dictionary, comprehensive prescription and over-the-counter drug information, interactive patient tutorials, health information in Spanish, access to current information on thousands of clinical trials and daily updates of news-worthy health information.

MEDLINEplus is not a ‘dot com’ Web site and does not contain advertisements or potentially damaging pop up windows. The information is provided by leading health and science research centers and is always quality filtered by licensed and respected medical professionals.

The Wicomico County Health Department was awarded a grant from the National Library of Medicine, National Institute of Health, through a health information services and public health partnership initiative. Through this partnership, the agency has launched the Electronic Health Resources for the Public program to spread the word on available online health resources. This program provides educational opportunities for the technologically underprivileged as well as budding development for community resource sharing. Some of the program’s key initiatives include assisting consumers with internet access and education thereof, sharing valuable information with area providers for use by office staff and for delivery to clientele, an all-encompassing media campaign and a multi-agency resource collaborative.

Provided here is a quick reference tool that you can print out to keep by your computer. This page contains information on additional National Library of Medicine and affiliate databases that we hope you will find to be useful both at home and with the populations that you serve.



HHS African American Infant Mortality Awareness Campaign

Know What to Do for Life Campaign, a new Health and Human Services (HHS) public education campaign aims to increase awareness among African Americans about the risk factors associated with infant mortality. The campaign will include radio and print advertisements featuring Gospel artists, as well as a toolkit for local not-for-profit groups. Information on the campaign can be found on the HHS Closing the Health Gap Web site www.healthgap.omhrc.gov or by calling 1-800-444-6472.



Answering Questions about HIPAA and Language Services in Health Care

HIPAA and Language Services in Health Care discusses how the Health Insurance Portability and Accountability Act’s (HIPAA’s) patient privacy rules apply to interpreters who provide language services to individuals with limited English proficiency in health care settings. The issue brief was prepared by the National Health Law Program with support from the California Endowment. Information is presented in a series of questions and answers addressing such topics as who is covered by the HIPAA privacy rules and how to know if the rules apply, what patient information is protected under HIPAA, when an interpreter can disclose protected patient information, HIPAA training for interpreters and who is responsible for providing training, and what to do if the interpreter believes that the privacy rules are being violated. The issue brief is available at www.healthlaw.org/pubs/200503.hipaaandinterpreters.pdf



Good Health Information On the World Wide Web



The home page of the U.S. National Library of Medicine® (NLM®), the world's largest medical library, contains over 12 million references to journal articles from 4,600 worldwide health science journals cited back to 1966 and is obtainable in PubMed®, MEDLINEplus®, and the NLM Gateway. Available at: www.nlm.nih.gov

Find the link to the NLM® and links to regional programs and services by visiting:

www.regionalresourcecenter.org



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MEDLINEplus—NLM's site for quality, up-to-date, and totally private consumer health information. Clinical trials, MEDLINE searches, drug information, encyclopedias, dictionaries, directories, news, interactive tutorials, and a Spanish version are included. Available at: medlineplus.gov

PubMed—Provides access, free of charge, to MEDLINE. Includes state-of-the-art retrieval features such as "related articles," links to related databases, and to publishers' full-text articles. Available at: pubmed.gov

Lonesome Doc®—An electronic order feature for obtaining a full-text copy of documents found in MEDLINE. Registration is required and local fees may apply. More information available at: www.nlm.nih.gov/loansomedoc/loansome_home.html

Clinical Trials.gov—Provides easy access to information on over 7,000 clinical research studies. Available at: www.clinicaltrials.gov

LOCATORplus—NLM's on-line catalog providing information about the Library's holdings of books, journal titles, and audiovisuals. Available at: www.locatorplus.gov

TOXNET®—An extensive collection of bibliographic and full-text information covering the effects of drugs and other chemicals on humans. Available at: www.toxnet.nlm.nih.gov

Tox Town—An interactive guide to commonly encountered toxic substances encountered in everyday places. Available at: www.toxtown.nlm.nih.gov

NLM Gateway—Provides as single access point for the many information resources of NLM. Available at: <http://gateway.nlm.nih.gov/gw/Cmd>

Images from the History of Medicine—A database of nearly 60,000 illustrations from the history of health sciences. Available at: www.nlm.nih.gov/hmd/index.html

Profiles in Science™—Provides access to the archival collections of pioneering biomedical scientists of the 20th century. Available at: www.profiles.nlm.nih.gov

Exhibit Program—promotes public education about science, medicine, and history through its creation of interactive exhibitions. Available at: www.nlm.nih.gov/hmd/about/exhibition/index.html

DIRLINE—Online directory of health organizations. Find addresses and phone numbers internationally at: <http://dirline.nlm.nih.gov>

Kidshealth.org—A service of the Nemours Foundation that provides families with accurate, up-to-date, and jargon-free health information ranging from birth to adolescence. Visit: www.kidshealth.org/



www.nlm.nih.gov

Reproductive Genetic Testing

Reproductive genetics, a field of medical genetics integrated with reproductive medicine, assisted reproduction, and developmental genetics, involves a wide array of medical procedures and genetic tests that are conducted with the intent of informing individuals about the possible outcomes of current or future pregnancies. The tests themselves can include the analysis of chromosomes, DNA, genes, and/or gene products to determine whether an alteration is present that is causing or is likely to cause a specific disease or condition.

Types of Tests

In general, reproductive genetic testing involves the following categories of tests:

Carrier screening is performed to determine whether an individual carries one copy of an altered gene for a particular recessive disease. The term recessive refers to diseases that will occur only if both copies of a gene have a disease-associated mutation; thus, each child born to two carriers of a gene mutation has a 25 percent risk of inheriting two altered genes, one from each parent, and thus being affected with the disorder. Examples of carrier tests include those for Tay-Sachs disease, sickle cell anemia, and cystic fibrosis. Couples are likely to have carrier tests if they are at higher risk of having a child with a specific disorder because of their family medical history or racial or ethnic heritage.

Preimplantation genetic diagnosis (PGD) is used following in vitro fertilization to diagnose a genetic disease or condition in an embryo. Preimplantation genetic diagnosis is essentially an alternative to prenatal diagnosis, as it allows testing before a pregnancy begins. Doctors can test the polar body of an egg cell or cells from an eight-cell embryo to identify embryos free from genetic disease or with specific traits. These embryos are transferred to the woman's womb

to initiate a pregnancy. Over 1000 babies have been born worldwide after undergoing the procedure, and the number is growing rapidly. Preimplantation genetic diagnosis has been applied to patients carrying chromosomal rearrangements, such as translocations, or those at risk of transmitting a single gene disorder to their offspring.

Preimplantation genetic diagnostic techniques have also been used to detect chromosomal abnormalities in women of advanced maternal age undergoing fertility treatment. These patients usually do not have a known heritable mutation or chromosomal abnormality. Rather, PGD is used to detect chromosomal abnormalities arising in meiosis or early rounds of mitosis that are more common in older women. More than 100 different single gene disorders have been diagnosed in preimplantation embryos and the number is increasing each year.

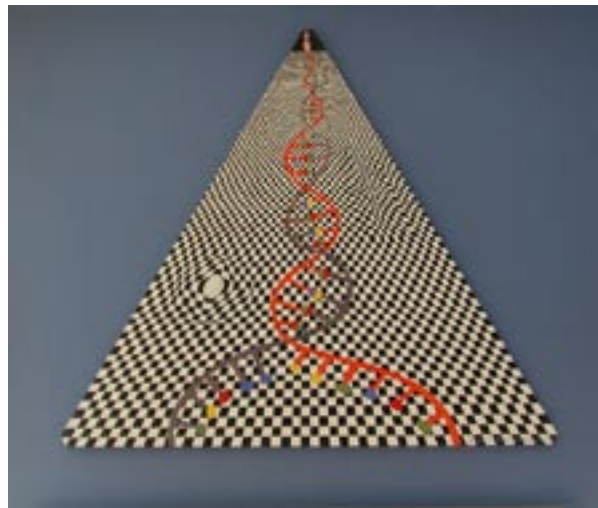
Prenatal testing is used to diagnose a genetic disease or condition in a developing fetus. Two broad categories of tests are available, invasive procedures in which a sample of fetal tissue is obtained, or non-invasive procedures in which the fetus is visualized

or a sample of mother's blood is obtained for testing. Amniocentesis and chorionic villus sampling (CVS) are the two most common invasive tests performed. Amniocentesis is done at 14 to 20 weeks gestation and involves inserting a needle through the mother's abdomen into the amniotic sac to obtain a sample of the amniotic fluid. The fluid can be tested for biochemical disorders and the fetal cells in the fluid can be tested for chromosome or gene abnormalities. CVS is done at 10

to 12 weeks gestation and involves inserting a catheter through the mother's cervix or abdomen to obtain a sample of placental tissue that can be analyzed for chromosome or gene abnormalities. Invasive tests involve some risk to the fetus.

The most common noninvasive tests are ultrasound and maternal serum screening. Ultrasound can be done at any time during pregnancy to visualize the fetus, to determine the size and position of the fetus, the size and position of the placenta, or the amount of amniotic fluid present. When done to look for structural abnormalities in the fetus, it is best done from 16 to 20 weeks. Maternal serum screening is done around 15 to 20 weeks gestation to measure certain markers in mother's blood that may indicate the presence of neural tube defects, certain other birth defects or chromosome abnormalities.

In any of these forms of prenatal testing, pre- and post-test genetic counseling is important so that the limitations and risks of the procedures and tests are known as well as any options available to the family if testing reveals that the fetus is affected with a disorder. Newborn screening (NBS) is one of the largest public



health activities in the United States. Historically, NBS was aimed at the early identification of infants who are affected by certain genetic, metabolic, or infectious conditions for which early diagnosis and treatment are available.

New technology has expanded the number of disorders that can be detected, but effective treatment is not yet available for all of them. States test blood spots collected from newborns for four to over 30 metabolic and genetic diseases, such as phenylketonuria, hypothyroidism,

galactosemia, sickle cell disease, and medium chain acyl CoA dehydrogenase deficiency. The goal of this screening is to identify affected newborns quickly in order to provide treatment that can usually prevent mental retardation, severe illness, or death.

Reproductive genetic testing raises a number of ethical issues. Americans have deeply held and widely varied views about the moral status of the embryo and the fetus. The public discussion of these new technologies reflects the controversy inherent in the topic. It is extremely important that the patient's views be recognized and honored when counseling for genetic testing is performed.

Modified from text provided by the National Human Genome Research Institute. Posted November 2002, available at: www.dnapolicy.org/genetics/reproGen.jhtml

For a thorough discussion on the Ethics of Reproductive Genetics, see "Reprogenetics and Public Policy" from the Hastings Center report by Erik Parens and Lori Knowles, published July-August 2003. This article can be accessed by going to: www.thehastingscenter.org/news/features/reproversight.asp



Prenatal Genetic Testing and Counseling Resources in the Counseling Resources in Maryland

Harvey Institute for Human Genetics

Genetic Counseling Section, Baltimore, MD
Staff US Genetic Board Certification/
Credential: American Board of Medical Genetics (Clinical Biochemical/Molecular Genetics, Clinical Cytogenetics, Clinical Genetics, Genetic Counseling, PhD Medical Genetics)

Appointments: Tel: 443-849-3131 Fax: 443-849-2919 E-mail: enichols@gbmc.org

Johns Hopkins Hospital

Prenatal Diagnostic Center and Treatment Center, Baltimore, MD

Staff US Genetic Board Certification/
Credential: American Board of Genetic Counseling, American Board of Medical Genetics (Clinical Cytogenetics, Clinical Genetics, Genetic Counseling)

Appointments: Tel: 410-955-3091 Fax: 443-287-2358

Mercy Medical Center

Antenatal Diagnostic Center
Baltimore, MD

Appointments: Tel: 410-332-9192 Fax: 410-244-0827 E-mail: ascaffe@hcmt.com

The Wilson Genetics Center
Bethesda, MD

An Outreach Clinic of: George Washington University Medical Faculty Associates
Washington, DC

Staff US Genetic Board Certification/
Credential: American Board of Medical Genetics (Clinical Genetics, Genetic Counseling)

Appointments: Tel: 202-741-3096 Fax: 202-741-2550 E-mail: wgc@mfa.gwu.edu

The Genetic Center of Baltimore
Owings Mills, MD

Staff US Genetic Board Certification/
Credential: American Board of Genetic Counseling, American Board of Medical Genetics (Clinical Genetics, Genetic Counseling, Molecular Genetic Pathology, PhD Medical Genetics)

Appointments: Tel: 410-581-8300 Fax: 410-581-8780 E-mail: mgeier@comcast.net



An Outreach Clinic of: Children's National Medical Center

Center for Prenatal Evaluation
Washington, DC

Staff US Genetic Board Certification/
Credential: American Board of Genetic Counseling, American Board of Medical Genetics (Clinical Biochemical Genetics, Clinical Genetics)

Appointments: Tel: 202-884-4166 Fax: 202-884-2390

Appointments 2: Tel: 202-884-2187

Greater Washington Maternal-Fetal Medicine and Genetics
Rockville, MD

Staff US Genetic Board Certification/
Credential: American Board of Genetic Counseling, American Board of Medical Genetics (Clinical Genetics, Genetic Counseling)

Appointments: Tel: 301-279-6060 Fax: 301-279-6345

Genetic Consultants of Maryland
Rockville, MD

Staff US Genetic Board Certification/
Credential: American Board of Genetic Counseling, American Board of Medical Genetics (Clinical Genetics, Genetic Counseling, Molecular Genetic Pathology, PhD Medical Genetics)

Appointments: Tel: 301-770-5300 Fax: 301-770-2005 E-mail: mgeier@erols.com

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Source: www.genetests.org

Breastfeeding Peer Counselors Support Maryland WIC Program Participants

Amy Resnik, MS, RD, CSP, LDN and Laurie Miele, BSN, RN, IBCLC

The Maryland Women, Infants and Children Program (WIC) has standardized its breastfeeding peer counselor program and is expanding it from three WIC local agencies to seven WIC local agencies, which serve a total of nine counties and Baltimore City. The program is modeled after WIC's peer counselor program in Harford County, which was funded for the past four years through the Maternal and Child Health's Crenshaw initiative. Research has shown that peer counselors have a positive effect on both breastfeeding initiation and duration. While breastfeeding initiation among Maryland WIC Program participants has increased from 13 percent in 1991 to over 55 percent in 2005, it still falls short of the national goal (75 percent), and breastfeeding duration at six months is well below the national goal. It is anticipated that the addition of trained peers to encourage pregnant women and to support breastfeeding women will result in more gains in breastfeeding initiation and duration.

Many families today do not have family members to assist with breastfeeding because many grandmothers of infants being born did not breastfeed. That leaves a gap for healthcare professionals to fill. Peers who have breastfed or are currently breastfeeding are able to fulfill this role, allowing healthcare professionals to reserve their time for those breastfeeding moms experiencing higher level problems.

The Maryland WIC Program's peer counselors are trained to focus on normal breastfeeding situations. They are able to promote breastfeeding prenatally and answer the myriad of questions that a pregnant couple may have. Peer counselors are also trained to educate and assist with facilitating breastfeeding, with particular focus on proper position, latch-on, and indicators that an infant is getting enough milk. Peer counselors work with breastfeeding moms as other issues arise, including options when returning to work, information about expressing breast milk, and storage of pumped milk. Peer counselors call prenatal and breastfeeding participants at regular intervals to check-in. Research has shown that breastfeeding moms often don't call for help before reaching for a bottle of infant formula. Thus, the periodic phone calls can reach those in need before they stop or reduce breastfeeding due to something that was not really a problem or that could have been overcome (often easily). In addition, in some counties, peer counselors facilitate breastfeeding support groups both in WIC and in the community.

While focusing on normal breastfeeding issues, peer counselors will serve as screeners when issues requiring professional intervention arise. When these occur, peer counselors will refer participants to International Board Certified Lactation Consultants, WIC professionals, or other healthcare professionals in their community.

The Maryland WIC Program currently has peer counselors in the following areas: Harford County, Cecil County, Montgomery County, Baltimore County, Baltimore City (through Johns Hopkins WIC Program), Caroline County, Talbot County, Dorchester County, Carroll County, and Prince George's County (through Greater Baden WIC Program). Peer counselors can be reached by calling the local WIC office.

For further information, call Laurie Miele, Maryland WIC Peer Counselor Program Coordinator, at 410-273-5658 or Amy Resnik, Maryland WIC Program Breastfeeding Promotion Coordinator, at 1-800-242-4WIC.



Breastfeeding Initiation Among Low Income Women

“Our findings indicate that there is room for improving health care system support for breastfeeding,” state the authors of an article published in the March/April 2005 issue of *Women’s Health Issues*. Breastfeeding initiation rates are still below the Healthy People 2010 objectives, which state that by 2010, 75 percent of mothers will initiate breastfeeding, and 50 percent will continue to breastfeed when their infants reach age 6 months. The article examines key variables and their impact on breastfeeding initiation among women with low incomes. The analysis includes sociodemographic characteristics and measures of attitudes, the health care system and family support, and perceived control over time and social constraints barriers to breastfeeding.

The study was conducted as part of the national Loving Support Makes Breastfeeding Work campaign. Study participants included a sample of women in Mississippi who were enrolled in Medicaid and who delivered an infant in spring 2000. A self-administered questionnaire was mailed to participating women in summer 2000 to collect data on infant feeding method, attitudes about benefits of and barriers to breastfeeding, perceived control, and sociodemographic characteristics. Telephone follow-up was conducted for women who did not respond to either of two mailings. A total of 733 women (61 percent) completed the survey, including 532 who completed mail surveys and 201 who completed telephone surveys.

The authors found that:

- * The breastfeeding initiation rate was 38 percent.
- * Women who were older, white, non-Hispanic, college-educated, married, and not WIC-certified were more likely to be breastfeeding than formula feeding at hospital discharge.
- * Knowledge of the benefits of breastfeeding was associated with higher breastfeeding rates, while embarrassment about breastfeeding was associated with lower rates.
- * Women who were encouraged to breastfeed by the hospital delivery nurse or lactation specialist/peer counselor were more than twice as likely than other women to initiate breastfeeding.
- * Women whose families encouraged formula feeding were half as likely as women whose families encouraged breastfeeding to initiate breastfeeding.
- * Adding the health care system support variables explained the association between breastfeeding initiation and women’s perceived control over time and social constraints barriers (school and work issues) to breastfeeding.

The authors conclude that supportive hospital practices, family interventions, and public health education campaigns are needed to promote breastfeeding in women with low incomes.

Khoury AJ, Moazzem SW, Jarjoura CM, et al. 2005. Breast-feeding initiation in low-income women: Role of attitudes, support, and perceived control. *Women’s Health Issues* 15(2):64-72.

MCH Training Program Web site Launched

The Maternal and Child Health (MCH) Training Program of the Maternal and Child Health Bureau has launched a new Web site to support the education and training of those working in the MCH professions. The MCH Training Program supports trainees, faculty, continuing education, and technical assistance. The new Web site provides information on new funding opportunities, writing a grant proposal, currently funded projects, and reporting requirements. The Web site also includes an events calendar, conference archives, a glossary, a downloadable PDF document library, and other resources relevant to the program. The Web site is available at www.mchb.hrsa.gov/training

MCH Research Program Web site Launched

The Maternal and Child Health (MCH) Research Program of the Maternal and Child Health Bureau (MCHB) has launched a new Web site to enhance dissemination of MCH Research Program activities and projects. The MCH Research Program supports applied research relating to MCH services that has the potential to improve health services and delivery of care for MCH populations. The site provides information on new funding opportunities and currently funded research projects. The site also includes an events calendar, conference archives, a program description, and the MCHB Strategic Research Issues, Fiscal Years 2004-2009. The Web site is available at www.mchb.hrsa.gov/research



Caring for African Pregnant Immigrant Women

Brenda J. Reynolds RN, High Risk Case Manager, Baltimore Medical System

The Highlandtown Community Health Center (HCHC) operated by Baltimore Medical System (BMS) is located in Baltimore City. This federally qualified health center (FQHC) provides prenatal care to a growing number of immigrant women from Africa. Most are young women from Cameroon, Liberia, Somalia, Sudan, Sierra Leone, the Democratic Republic of the Congo, Kenya and Ghana. Other pregnant immigrants seen at HCHC include women who are Latino, Middle Eastern, Asian and a small number from Eastern Europe. BMS is a not-for-profit community-based organization that operates seven FQHC centers. Originally with locations only in East Baltimore, BMS now has facilities in east, northwest and southwest Baltimore City as well as east and southwest Baltimore County. Ob/Gyn providers see patients for prenatal care at five BMS centers. HCHC currently sees the largest number of non English speaking immigrants and refugees.

Newly arrived immigrants from The Refugee Resettlement Center are referred to HCHC for screenings and primary health care. In 2003 immigrants from 34 different countries received health care services through BMS. 150 different languages are spoken by these individuals. The staff at the Refugee Resettlement work intensively with immigrants to assist them with housing, health care access and other issues. An additional resource has been the use of the language line which enables BMS physicians and other clinical staff to communicate with select patients. Our International Services Program staff actively work with HCHC clinicians to insure that pregnant immigrant women and their families understand why a test or procedure is needed and what they can do to remain healthy. Bilingual and bicultural clinicians and support staff have been hired at BMS to enhance communication with our newly arrived patients.

The following key points play a critical role in how care is delivered and utilized by these women.

- ★ In traditional African society, a women's social status is defined by her place of origin, kinship, marital status and educational background. An immigrant woman's limited capacity in English and cultural familiarity poses distinct disadvantages during pregnancy. If the husband has found employment during the day hours the pregnant women may miss appointments because she lacks a way to get to her health center unassisted.

- ★ Language, customs, diet, education, lifestyle habits, religious beliefs, dress and male/female roles affect how well immigrants integrate themselves into American society. Age, socio-economic status, political orientation and occupation are other facets of cultural diversity. These variables affect pregnancy, childbirth, lactation and the post partum period.

- ★ A simple procedure like having blood drawn may pose significant issues for several reasons. The fear may exist that learning one has a disease or infection may mean deportation. Who else has privy to this personal information? If there is a problem, can the woman and her family afford the treatment?

- ★ If reports are needed from another provider outside the U.S. how long will it take to receive this information? Lack of transportation to and from prenatal appointments, specialized testing and sonograms will play a role in whether these services are properly utilized.

- ★ Refugee families may not know how to independently access health facilities or may shy away from public health services in general because they fear immigration authorities.

- ★ Mistrust of health care systems, ambivalence or fear of mistreatment impact how these expectant women may respond to prenatal care.

- ★ Perceptions regarding disease, illness, beliefs about deceased ancestors, self treatment /or traditional healers have shaped an immigrant's past experience.

- ★ Conflicts regarding the perception of time for the mother/family frequently result in an underutilization of prenatal services.

- ★ The American health care system has a time orientation based on a strict adherence to appointments for scheduled services. African immigrants have a different perception of time and how our health care system works. This leads to low compliance with treatment plans or medication use. An individual's income, gender, insurance, health status and education determine how their cultural beliefs will impact medical compliance during an illness, disease or pregnancy. A similar set of variables may guide an immigrants' use or rejection of health care services.

Health organizations that work with immigrants and refugees report that long term civil wars in third world countries, political instability, poverty, poor nutrition, infectious diseases and violence impact pregnancy outcomes and childbirth. The pre-pregnancy health of immigrant women may place them at high risk for complications.

In the U.S. and other developed nations science and technology guide treatment plans, intuition and the spirit worlds are viewed as suspect. Clinicians who care for these women are unfamiliar with the nuances of immigrant cultural practices as these women navigate pregnancy and childbirth away from their extended families.

Obstetrical providers utilize modern technology to support good birth outcomes. Attention and resources are directed toward reducing maternal/ infant morbidity and mortality. Refugees and immigrants experience overwhelming choices within the context of being newly arrived and pregnant. A first step for health care staff is becoming culturally competent. At the time of an encounter, little is known about immigrants beyond their appearance, gender and dress. Becoming knowledgeable about other ethnic groups begins with the cultural desire to learn more. "Cultural desire is the pivotal and key construct of cultural competence." (Campinha-Bacote, 1999).

DHMH Offers Smoking Cessation for Pregnant Women

Despite widespread knowledge of the harmful effects of smoking on pregnant women and their babies, recent statewide studies show that eight percent of Maryland's pregnant women continue to use tobacco products. Within the health department client population, this number rises to 25 percent. The good news is that quit rates for pregnant women increase by 10 to 20 percent when smokers are counseled by their providers. Given these facts, smoking cessation interventions present a measurable way to reduce poor pregnancy outcomes like miscarriage, premature birth, preterm delivery and low birth weight babies.

Maryland Department of Health and Mental Hygiene's Center for Health Promotion, Education and Tobacco Use Prevention offers two programs directed at reducing and preventing smoking in this vulnerable population. The Smoking Cessation in Pregnancy (SCIP) program works to empower and assist pregnant women in quitting smoking. The Body Sense teen intervention works similarly to educate young, preconceptional female smokers about smoking-related health risks and encourages them to quit. Designed for use in clinical settings, both programs use motivational interviewing to move women along the stages of change continuum. A directive, client-centered counseling method, motivational interviewing helps women explore and resolve ambivalence about behavior change. The two programs also use the federal clinical practice guideline strategies called the "Five A's" to lead clients toward decision-making and positive behavior change.

The Smoking Cessation in Pregnancy (SCIP) program began with a federal grant in 1988. The goal of the program is to train the staff of local health departments and managed care organizations to facilitate quitting among their pregnant clients, working toward the Healthy Maryland 2010 goals of reducing infant mortality and low birth weight. The SCIP training program for health professionals is a two-hour workshop that includes background data on pregnant smokers in Maryland and the United States, instruction on the motivational interviewing technique and stages of change continuum, protocol for both the SCIP and Teen interventions, and role-playing exercises.

The SCIP program provides pregnant clients with the manual *Quit and Be Free*, to take home, along with a Quit Kit of items to help redirect and replace the smoking activity. The Quit Kit contains a toothbrush and toothpaste, cinnamon sticks, paper clips, and a CD of relaxation techniques, along with other helpful items.

In the family planning clinic setting, The Body Sense teen intervention uses a colorful, youth-oriented newsletter to address the ways in which teen girls are particularly affected by smoking. Since 41 percent of live births in Maryland are unplanned pregnancies (Pregnancy Risk Assessment Monitoring System, 2003), reducing smoking among preconceptional women can offer added advantages with respect to pregnancy outcomes. In an upbeat, non-preaching style, Body Sense explores smoking in relation to topics of interest to the young female population: appearance and body image, relationships, and peer pressure. Teen clients are counseled and provided with a copy of the Body Sense newsletter to take home.

For more information about DHMH's smoking cessation programs for women, contact Jade Leung at 410-767-2919.



Prenatal Exposure to Air Pollution Associated With Genetic Abnormalities Linked to Cancer

Nonsmoking New York City women who are exposed to high levels of air pollution while pregnant are more likely to give birth to infants with genetic abnormalities linked to cancer than nonsmoking women who were exposed to lower levels of air pollution. Dr. Frederica Perera, Director of the Center for Children's Environmental Health at the Columbia University Mailman School of Public Health and senior author of the study, and colleagues studied 60 pregnant nonsmokers living in low-income New York City neighborhoods of Harlem, Washington Heights and South Bronx. The women wore air monitors during the third trimester of their pregnancies to measure their exposure to combustion-related pollutants.

When the women's infants were born, researchers analyzed chromosomes collected using their umbilical cord blood and discovered a significant association between the level of prenatal exposure to pollutants and genetic abnormalities. Infants born to women with the highest levels of exposure to air pollutants had about 50 percent more genetic abnormalities than infants born to women with lower levels of exposure to the pollutants.

Perera stated, "Cancer is a disease of accumulated genetic damage, and this new finding shows this process can begin in utero," adding, "Now that we have evidence that the process begins so early, we can be more aware of the risks." Perera said the study does not allow scientists to estimate the "precise increase in cancer risk," but she added that the findings "underscore the need" for local and federal government officials to "take steps to protect children. The study was funded by NIH's National Institute of Environmental Health Sciences, the U.S. Environmental Protection Agency and several private foundations.

Chromosomal Aberrations in Cord Blood Are Associated with Prenatal Exposure to Carcinogenic Polycyclic Aromatic Hydrocarbons, Frederica P. Perera, et al, *Cancer Epidemiology Biomarkers and Prevention*, Vol. 14, 506-511, February 2005

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Baby's Beautiful Brain

Patricia Deitz, L.C.S.W.-C., Program Manager, Healthy Families, Queen Anne's/Talbot County

Just days after conception, the newly fertilized egg has divided once, and then again, into four cells. One of these four cells will become the baby's brain. If a pregnant woman smokes cigarettes, uses drugs or certain medications, drinks alcohol, lacks pre-natal care, or eats poorly, the baby's developing brain can be permanently damaged. After four months, the fetal brain has one billion cells, and is growing at the rate of 50,000 cells per second. In a healthy newborn, the brain is the only body organ that is incomplete at birth, and it already has 100 billion neurons and 500 trillion of the brain connectors known as synapses. These connectors are the "wiring" that carries messages for seeing and hearing, moving, feeling, learning and thinking. The synapses continue to develop with astonishing speed. By eight months, a baby has 1,000 trillion synapses. With those synapses, an eight-month old can already enjoy silly games, imitate sounds, crawl, and reach for a toy. In the first year, the brain uses 62 percent of a baby's caloric intake and doubles in weight.

Brain wiring and rewiring occur as a result of positive and negative experiences: those that are repeated continue to build more connections. Natural brain development also includes the "pruning" away of synapses that are not used frequently. This is why, for example, a baby born in any culture can learn the language it hears, but after a few years, other languages become much more difficult to learn. It is also why your toddler loves you to repeat favorite stories, games and songs. From our first days of life, we learn by repetition.

The brain reaches 90 percent of its development by age three. The foundation for how your baby will see the world, and take his or her place in it, is built before a child even begins school. Early childhood experts now say that the experiences you repeat for your baby should include these ABC's:

Attention. A child's brain is stimulated by a variety of wonderful—and Ordinary—sights, smells, sounds, and sensations, but all in moderation. Babies' temperaments differ, so when baby reacts with pleasure or distress, the caretaking adults must adapt the stimulation to the baby's comfort level.

Bonding. The brain's capacity for trust, security and self-esteem is built by repeated experiences of a parent's loving touch, consistent care, smiling eye contact, play and just plain admiration.

Communication. Talking, singing, rhyming and reading to baby are great even before birth, and must be part of every day after! Young children who don't receive enough of these first ABC's don't build the rich network of synapses they will need for success in life. By the time the child is ten years old, unused synapses have been pruned away, leaving the 500 trillion or so that the adult brain contains. Baby's brains achieve all this development naturally. They don't need fancy toys and techniques. Just use these ABC's and baby will have a beautiful brain to last a lifetime. Visit www.zerotothree.org, www.educarer.com, www.readyatfive.org, www.countdownMD.org; and www.patnc.org



Updated HIV Testing Fact Sheet Available

In advance of National HIV Testing Day on June 27, the Kaiser Family Foundation has updated the fact sheet HIV Testing in the United States with the latest data and state-specific information on HIV testing and reporting policies.

National HIV Testing Day, sponsored by the National Association of People with AIDS, is held each year to bring attention to the importance of getting tested for HIV. Knowledge of one's HIV status is critical for both prevention and treatment efforts. However, of the 850,000 to 950,000 people estimated to be living with HIV/AIDS in the U.S., approximately 25 percent do not know they are infected.

The updated fact sheet is available online at www.kff.org/hiv aids/6094-04.cfm. State-specific HIV testing and reporting policies are also available at www.statehealthfacts.org/r/hivtest.cfm. To learn about how the Emmy and Peabody-award winning campaign, KNOW HIV/AIDS is supporting National HIV Testing Day, visit www.kff.org/hiv aids/PHIP060605NR.cfm. KNOW HIV/AIDS is a partnership between Kaiser and Viacom to help educate and inform young people about HIV/AIDS.

For more information contact Rob Graham at 650-854-9400 or rgraham@kff.org.

Maryland AIDS Bilingual Hotlines
1-800-6252 (English and TTY)
1-800-553-3140 (Español and TTY)

Ten Tips For Parents To Help Their Children Avoid Teen Pregnancy

The National Campaign to Prevent Teen Pregnancy has reviewed recent research about parental influences on children's sexual behavior and talked to many experts in the field, as well as to teens and parents themselves. The following "Ten Tips" are based on common sense and on what kids themselves have on their minds when it comes to sex. The most important factor is to maintain strong, close relationships with children and teens, setting clear expectations, and communicating honestly and often with them about important matters. If caring adults are all on the same "wavelength" about the issues covered here, young people are given more consistent messages.

Briefly excerpted here, for the full article go to: www.teenpregnancy.org/resources/reading/tips/tips.asp

So, What to Do?

1. Be clear about your own sexual values and attitudes. Communicating with your children about sex, love, and relationships is often more successful when you are certain in your own mind about these issues.

2. Talk with your children early and often about sex, and be specific. Kids have lots of questions about sex, and they often say that the source they'd most like to go to for answers is their parents.

Here are the kinds of questions kids say they want to discuss: How do I know if I'm in love? Will sex bring me closer to my girlfriend/boyfriend? How will I know when I'm ready to have sex? Should I wait until marriage? Will having sex make me popular? Will it make me more grown-up and open up more adult activities to me? How do I tell my boyfriend that I don't want to have sex without losing him or hurting his feelings? How do I manage pressure from my girlfriend to have sex? How does contraception work? Are some methods better than others? Are they safe? Can you get pregnant the first time?

3. Supervise and monitor your children and adolescents. Establish rules, curfews, and standards of expected behavior, preferably through an open process of family discussion and respectful communication.

4. Know your children's friends and their families. Friends have a strong influence on each other, so help your children and teenagers become friends with kids whose families share your values.

5. Discourage early, frequent, and steady dating. Group activities among young people are fine and often fun, but allowing teens to begin steady, one-on-one dating much before age 16 can lead to trouble.

6. Take a strong stand against your daughter dating a boy significantly older than she is. And don't allow your son to develop an intense relationship with a girl much younger than he is.

7. Help your teenagers to have options for the future that are more attractive than early pregnancy and parenthood.

8. Let your kids know that you value education highly. Encourage your children to take school seriously and set high expectations about their school performance.

9. Know what your kids are watching, reading, and listening to. The media (television, radio, movies, music videos, magazines, the Internet) are chock full of material sending the wrong messages.

10. These first nine tips for helping your children avoid teen pregnancy work best when they occur as part of strong, close relationships with your children that are built from an early age. Strive for a relationship that is warm in tone, firm in discipline, and rich in communication, and one that emphasizes mutual trust and respect.

Excerpted from Ten Tips for Parents to Help Their Children Avoid Teen Pregnancy: www.teenpregnancy.org/resources/reading/tips/tips.asp

For information about teen pregnancy resources in Maryland, contact Andy Hannon at 410-767-6716 or hannona@dhmh.state.md.us.



Tools to Help Families Communicate About Sexuality

As part of its From Research to Practice series, Advocates for Youth has published two updated briefs on translating research into science-based practices to prevent adolescent pregnancy and HIV and other sexually transmitted infections. Resources for Families on Parent-Child Communication provides a selected list of resources and materials to help parents talk with their children and adolescents about sexuality. Resources are arranged according to the following topics: web sites for parents, web sites for children and adolescents, books and videotapes, and organizations. The brief is available at www.advocatesforyouth.org/publications/frtp/resources.htm

Are You an Askable Parent? discusses what it means to be a parent that children and adolescents feel comfortable about coming to with questions and also provides tips for parents on talking with children and adolescents about sexuality. The brief is available at

www.advocatesforyouth.org/publications/frtp/askable.htm



Calendar Events

July

Understanding Infant Adoption

July 19-21

Adoptions Together, a licensed child placement agency, is hosting the National Infant Adoption Training Initiative for health care counselors in Maryland and Washington, DC. The training, "Understanding Infant Adoption," is three days (July 19-21) for counselors. Nurses and other health care workers are asked to attend Day 1 of the training to provide clinic context for the trainers. 6.6 contact hours are offered. The training is a TBD site in Washington, DC.

For more information, please contact Susan Ogden, Domestic Program Director at Adoptions Together: sogden@adoptionstogether.org

calendar

Please be sure and send in your calendar events well in advance. The Perinatal Network is a quarterly and in order to be sure your event is listed in time for readers to notice, and to avoid any production delays, advance submission is necessary.

Please send all calendar events to perinatalnetwork@livingmind.com